

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016863

STATE FILE NUMBER

523

FILED MAY 25 1959

Registration District No. 042

Primary Registration District No. 1000

Registrar's No.

300  
1-57

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		c. CITY OR TOWN St. Joseph	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2916 Messanie St.		Length of stay in lb 40 years	
3. NAME OF DECEASED (Type or print) First Middle Last ALPHA MAY RUSH		4. DATE OF DEATH Month Day Year May 15, 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (City and state or country) Springfield, Mo.
13a. FATHER'S NAME William Carlton		13b. MOTHER'S MAIDEN NAME Elizabeth Valentine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Sarah Drury, 2916 Messanie, St. Joseph, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General Carcinomatous Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Metastasis Cervical Cancer DUE TO (c): PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171x		INTERVAL BETWEEN ONSET AND DEATH months months	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from Jan 19 59 to May 15 59 and last saw her alive on May 12 1959 Death occurred at 12:40 p. m on the date stated above; and to the best of my knowledge from the causes stated		22a. SIGNATURE Dr. S. F. Melaney M.D. (Degree or title)	
22b. ADDRESS 214 N. Park Street St. Joseph, Mo.		22c. DATE SIGNED May 15 59	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/18/1959	
23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION (City, town, or county) St. Joseph Missouri	
24. FUNERAL DIRECTOR Heaton-Bowman		25. DATE RECD. BY LOCAL REG. May 18, 1959	
ADDRESS St. Joseph, Mo.		26. REGISTRAR'S SIGNATURE Mrs. Clark Larkell	

Dr. S. F. Melaney  
All diseases in Part I must be causally related.  
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *William J. Phillips* .....

Licensed Embalmer No. *4535* .....

P. O. Address *St. Joseph 420* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.